This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0010	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/26/2018 3:02 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/26/2018 Time: 3:02 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. JOSEPH HOSPITAL & HEALTH CENTER (15-0010) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	166,112	17,147	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	2,196	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	168,308	17,147	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 12:03 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1907 WEST SYCAMORE STREET	PO Box:			1.00
2.00	City: KOKOMO	State: IN	Zip Code: 46901	County: HOWARD	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. JOSEPH HOSPITAL & HEALTH CENTER	150010	29020	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	ST. JOSEPH ACUTE REHAB	15T010	29020	5	07/01/2002	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	433	32	6	3	4,607	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	15	0	0	107		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 12:03 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 12:03 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 12:03 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

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		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	625,722	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2018 12:03 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 250 W 96TH STREET, SUITE 215	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46260	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2016	12/31/2016	170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/26/2018 12:03 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/08/2018	Y	10/08/2018	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/26/2018 12:03 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RONALD	HELMS	41.00
42.00	Enter the employer/company name of the cost report preparer.	ASCENSION HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3234	RONALD.HELMS@ASCENSION.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0010	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/26/2018 12:03 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	NET REVENUE MANAGEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2018 12:03 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	86	31,390	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		86	31,390	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	13	4,745	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		99	36,135	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	18	6,570		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		117				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		8	2,920			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2018 12:03 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,581	190	14,748			1.00
2.00	HMO and other (see instructions)	2,104	4,583				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	378	107				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,581	190	14,748			7.00
8.00	INTENSIVE CARE UNIT	1,318	257	1,812			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		51	2,162			13.00
14.00	Total (see instructions)	6,899	498	18,722	0.00	527.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	2,475	15	3,547	0.00	17.10	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	544.10	27.00
28.00	Observation Bed Days		0	1,031			28.00
29.00	Ambulance Trips	2,197					29.00
30.00	Employee discount days (see instruction)			186			30.00
31.00	Employee discount days - IRF			43			31.00
32.00	Labor & delivery days (see instructions)	0	0	457			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2018 12:03 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,771	123	5,521	1.00
2.00	HMO and other (see instructions)			437	1,534		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,771	123	5,521	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	223	14	322	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 11/26/2018 12:03 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	35,616,017	117,898	35,733,915	1,131,712.00	31.58	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		268,927	0	268,927	2,704.00	99.46	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		1,042,303	0	1,042,303	10,233.00	101.86	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		2,276,931	0	2,276,931	59,783.00	38.09	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		2,255,312	224,464	2,479,776	78,359.00	31.65	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		724,385	0	724,385	8,453.00	85.70	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		6,928,420	0	6,928,420	156,482.00	44.28	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,985,711	0	8,985,711			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		616,798	0	616,798			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		66,306	0	66,306			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		256,988	0	256,988			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	-40,019	117,898	77,879	2,336.00	33.34	26.00
27.00	Administrative & General	5.00	4,519,849	0	4,519,849	109,608.00	41.24	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II | Date/Time Prepared: 11/26/2018 12:03 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		10,900,287	0	10,900,287	194,825.00	55.95	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	292,632	0	292,632	15,875.00	18.43	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,474,830	0	1,474,830	68,078.00	21.66	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		549,515	0	549,515	25,194.00	21.81	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,550,060	0	1,550,060	42,611.00	36.38	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,742,622	0	1,742,622	41,664.00	41.83	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part III | Date/Time Prepared: 11/26/2018 12:03 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		45,221,415	117,898	45,339,313	1,349,793.00	33.59	1.00
2.00	Excluded area salaries (see instructions)		2,255,312	224,464	2,479,776	78,359.00	31.65	2.00
3.00	Subtotal salaries (line 1 minus line 2)		42,966,103	-106,566	42,859,537	1,271,434.00	33.71	3.00
4.00	Subtotal other wages & related costs (see inst.)		7,652,805	0	7,652,805	164,935.00	46.40	4.00
5.00	Subtotal wage-related costs (see inst.)		9,052,017	0	9,052,017	0.00	21.12	5.00
6.00	Total (sum of lines 3 thru 5)		59,670,925	-106,566	59,564,359	1,436,369.00	41.47	6.00
7.00	Total overhead cost (see instructions)		20,989,776	117,898	21,107,674	500,191.00	42.20	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part IV Date/Time Prepared: 11/26/2018 12:03 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,798,792	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	476,610	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	-327,815	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	4,273,034	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	825,859	9.00
10.00	Dental, Hearing and Vision Plan	6,367	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	-11,851	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-2,695	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	256,585	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	71,886	14.00
15.00	'Workers' Compensation Insurance	157,564	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,364,445	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	3,320	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	33,702	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,925,803	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part V Date/Time Prepared: 11/26/2018 12:03 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	724,385	9,925,803	1.00
2.00	Hospital	724,385	9,925,803	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 11/26/2018 12:03 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.227394	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	11,633,322	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	82,691,621	6.00
7.00	Medicaid cost (line 1 times line 6)	18,803,578	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	7,170,256	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	7,170,256	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	11,145,385	5,530,922	16,676,307	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,534,394	5,530,922	8,065,316	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,534,394	5,530,922	8,065,316	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,000,931	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	324,581	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	499,356	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,501,575	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	743,618	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	8,808,934	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	15,979,190	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/26/2018 12:03 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,601,351	2,601,351	565,323	3,166,674	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,069,190	2,069,190	0	2,069,190	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-40,019	8,664,133	8,624,114	0	8,624,114	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,519,849	33,489,251	38,009,100	11,479	38,020,579	5.00
7.00	00700	OPERATION OF PLANT	292,632	3,794,246	4,086,878	0	4,086,878	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	509,679	509,679	8.00
9.00	00900	HOUSEKEEPING	0	2,135,826	2,135,826	-461,297	1,674,529	9.00
10.00	01000	DIETARY	0	2,379,202	2,379,202	-1,564,184	815,018	10.00
11.00	01100	CAFETERIA	0	0	0	1,564,184	1,564,184	11.00
13.00	01300	NURSING ADMINISTRATION	1,550,060	198,976	1,749,036	0	1,749,036	13.00
15.00	01500	PHARMACY	1,742,622	301,131	2,043,753	0	2,043,753	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,365	2,365	0	2,365	16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	84,281	34,169	118,450	224,464	342,914	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,180,238	1,369,249	6,549,487	433,828	6,983,315	30.00
31.00	03100	INTENSIVE CARE UNIT	1,260,101	215,842	1,475,943	0	1,475,943	31.00
41.00	04100	SUBPROVIDER - IRF	1,012,706	131,605	1,144,311	0	1,144,311	41.00
43.00	04300	NURSERY	0	0	0	525,402	525,402	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,714,760	2,302,521	6,017,281	0	6,017,281	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,115,104	436,065	2,551,169	-959,230	1,591,939	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,558,756	1,085,048	2,643,804	-225,565	2,418,239	54.00
54.01	03630	ULTRA SOUND	322,778	66,167	388,945	0	388,945	54.01
56.00	05600	RADIOISOTOPE	730,929	465,537	1,196,466	0	1,196,466	56.00
57.00	05700	CT SCAN	390,264	49,760	440,024	0	440,024	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	298,992	31,426	330,418	0	330,418	58.00
59.00	05900	CARDIAC CATHETERIZATION	70,165	80,819	150,984	0	150,984	59.00
60.00	06000	LABORATORY	0	5,647,152	5,647,152	0	5,647,152	60.00
65.00	06500	RESPIRATORY THERAPY	1,171,050	239,206	1,410,256	0	1,410,256	65.00
66.00	06600	PHYSICAL THERAPY	3,125,582	699,584	3,825,166	-1,218,816	2,606,350	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	945,342	945,342	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	235,646	235,646	68.00
69.00	06900	ELECTROCARDIOLOGY	658,428	100,404	758,832	0	758,832	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	402,697	200,444	603,141	-9,453	593,688	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	280,388	1,257,476	1,537,864	0	1,537,864	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,926,467	2,926,467	0	2,926,467	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,514,098	4,514,098	11,373,013	15,887,111	73.00
74.00	07400	RENAL DIALYSIS	0	276,082	276,082	0	276,082	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,330,419	476,803	1,807,222	0	1,807,222	76.00
76.01	03190	CHEMOTHERAPY	479,139	15,908,687	16,387,826	-11,373,013	5,014,813	76.01
76.02	03330	ENDOSCOPY	91,919	119,784	211,703	0	211,703	76.02
76.03	03950	WOUND CARE CENTER	225,151	584,191	809,342	-4,400	804,942	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,888,701	297,083	2,185,784	0	2,185,784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	776,126	154,817	930,943	0	930,943	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		572,402	572,402	-572,402	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,233,818	95,878,559	131,112,377	0	131,112,377	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	72,966	1,903,363	1,976,329	0	1,976,329	192.00
192.01	19201	MARKETING	0	311	311	0	311	192.01
192.02	19202	EDUCATION CENTER	0	20,716	20,716	0	20,716	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	8,460	8,460	0	8,460	194.01
194.02	07952	CLINIC OF HOPE	309,233	62,533	371,766	0	371,766	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	35,616,017	97,873,942	133,489,959	0	133,489,959	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/26/2018 12:03 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-552,671	2,614,003		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,069,190		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,913	8,641,027		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,604,762	29,415,817		5.00
7.00	00700	OPERATION OF PLANT	-22,259	4,064,619		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	509,679		8.00
9.00	00900	HOUSEKEEPING	0	1,674,529		9.00
10.00	01000	DIETARY	-510,006	305,012		10.00
11.00	01100	CAFETERIA	0	1,564,184		11.00
13.00	01300	NURSING ADMINISTRATION	-1,675	1,747,361		13.00
15.00	01500	PHARMACY	-11,219	2,032,534		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-484	1,881		16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	-23,325	319,589		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-600,468	6,382,847		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,475,943		31.00
41.00	04100	SUBPROVIDER - IRF	-600	1,143,711		41.00
43.00	04300	NURSERY	0	525,402		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-702	6,016,579		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-10	1,591,929		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-27,322	2,390,917		54.00
54.01	03630	ULTRA SOUND	0	388,945		54.01
56.00	05600	RADIOISOTOPE	-109,601	1,086,865		56.00
57.00	05700	CT SCAN	0	440,024		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	330,418		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	150,984		59.00
60.00	06000	LABORATORY	-655	5,646,497		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,410,256		65.00
66.00	06600	PHYSICAL THERAPY	-26,455	2,579,895		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	945,342		67.00
68.00	06800	SPEECH PATHOLOGY	0	235,646		68.00
69.00	06900	ELECTROCARDIOLOGY	0	758,832		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	593,688		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,003	1,536,861		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,926,467		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,887,111		73.00
74.00	07400	RENAL DIALYSIS	0	276,082		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-579,225	1,227,997		76.00
76.01	03190	CHEMOTHERAPY	-52,567	4,962,246		76.01
76.02	03330	ENDOSCOPY	0	211,703		76.02
76.03	03950	WOUND CARE CENTER	-2,956	801,986		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	2,185,784		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-9,266	921,677		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,120,318	119,992,059		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,976,329		192.00
192.01	19201	MARKETING	598,670	598,981		192.01
192.02	19202	EDUCATION CENTER	0	20,716		192.02
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	FOUNDATION	0	0		194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	8,460		194.01
194.02	07952	CLINIC OF HOPE	0	371,766		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,521,648	122,968,311		200.00

RECLASSIFICATIONS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/26/2018 12:03 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LAUNDRY AND LINEN RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	509,679	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	509,679	
	B - LABOR DELIVERY_OB_NURSERY RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	359,675	74,153	1.00
2.00	NURSERY	43.00	435,596	89,806	2.00
	TOTALS		795,271	163,959	
	C - DIETARY_CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	0	1,564,184	1.00
	TOTALS		0	1,564,184	
	D - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	565,323	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	7,079	2.00
	TOTALS		0	572,402	
	E - CHEMOTHERAPY DRUG RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,373,013	1.00
	TOTALS		0	11,373,013	
	F - PT_OT_ST RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	772,449	172,893	1.00
2.00	SPEECH PATHOLOGY	68.00	192,549	43,097	2.00
	TOTALS		964,998	215,990	
	G - AH-RAD TECH PRECEPTING EXPENSE				
1.00	ALLIED HEALTH-RAD TECH PROGRAM	23.00	224,464	0	1.00
	TOTALS		224,464	0	
	H - PTO ACCRUAL				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	117,898	0	1.00
	TOTALS		117,898	0	
	I - RECLASS CONSULTING EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,400	1.00
	TOTALS		0	4,400	
500.00	Grand Total: Increases		2,102,631	14,403,627	500.00

RECLASSIFICATIONS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/26/2018 12:03 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LAUNDRY AND LINEN RECLASS						
1.00	HOUSEKEEPING	9.00	0	461,297	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,101	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	11,518	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	14,437	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	11,873	0		5.00
6.00	ELECTROENCEPHALOGRAPHY	70.00	0	9,453	0		6.00
	TOTALS		0	509,679			
	B - LABOR DELIVERY_OB_NURSERY RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	795,271	163,959	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		795,271	163,959			
	C - DIETARY_CAFETERIA RECLASS						
1.00	DIETARY	10.00	0	1,564,184	0		1.00
	TOTALS		0	1,564,184			
	D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	572,402	11		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	572,402			
	E - CHEMOTHERAPY DRUG RECLASS						
1.00	CHEMOTHERAPY	76.01	0	11,373,013	0		1.00
	TOTALS		0	11,373,013			
	F - PT_OT_ST RECLASS						
1.00	PHYSICAL THERAPY	66.00	964,998	215,990	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		964,998	215,990			
	G - AH-RAD TECH PRECEPTING EXPENSE						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	224,464	0	0		1.00
	TOTALS		224,464	0			
	H - PTO ACCRUAL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	117,898	0		1.00
	TOTALS		0	117,898			
	I - RECLASS CONSULTING EXPENSE						
1.00	WOUND CARE CENTER	76.03	0	4,400	0		1.00
	TOTALS		0	4,400			
500.00	Grand Total: Decreases		1,984,733	14,521,525			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/26/2018 12:03 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	722,779	0	0	0	0	1.00
2.00	Land Improvements	1,764,978	0	0	0	0	2.00
3.00	Buildings and Fixtures	56,139,890	0	0	0	0	3.00
4.00	Building Improvements	9,769,525	734,262	0	734,262	0	4.00
5.00	Fixed Equipment	21,765,515	0	0	0	0	5.00
6.00	Movable Equipment	39,537,796	1,751,118	0	1,751,118	31,101	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	129,700,483	2,485,380	0	2,485,380	31,101	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	129,700,483	2,485,380	0	2,485,380	31,101	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	722,779	0	1.00
2.00	Land Improvements	1,764,978	0	2.00
3.00	Buildings and Fixtures	56,139,890	0	3.00
4.00	Building Improvements	10,503,787	0	4.00
5.00	Fixed Equipment	21,765,515	0	5.00
6.00	Movable Equipment	41,257,813	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	132,154,762	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	132,154,762	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 11/26/2018 12:03 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,601,351	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,069,190	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,670,541	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2,601,351	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,069,190	2.00
3.00	Total (sum of lines 1-2)	0	4,670,541	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/26/2018 12:03 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	87,674,930	0	87,674,930	0.689199	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	39,537,796	0	39,537,796	0.310801	0	2.00
3.00	Total (sum of lines 1-2)	127,212,726	0	127,212,726	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,614,003	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,069,190	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,683,193	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	2,614,003	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,069,190	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	4,683,193	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/26/2018 12:03 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	B	-14,000	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-8,595	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,478,407			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	641,923			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-466,286	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-11,219	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-484	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)	B	-23,325	ALLIED HEALTH-RAD TECH PROGRAM	23.00	0	19.00
20.00	Vending machines	B	-26,083	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MEALS ON WHEELS	B	-17,637	DIETARY	10.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/26/2018 12:03 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.01
33.02	BUILDING RENTAL INCOME-PROPERTY MGMT	B	-16,997	OPERATION OF PLANT	7.00	0	33.02
33.03	BUILDING RENTAL INCOME-CHEMOTHERAPY	B	-21,900	CHEMOTHERAPY	76.01	0	33.03
33.04	BUILDING RENTAL INCOME-WOUND CARE	B	-2,956	WOUND CARE CENTER	76.03	0	33.04
33.05	BUILDING RENTAL INCOME-MAMMOGRAPHY	B	-2,205	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	ADMINISTRATIVE FEES	B	-35	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MISC. INCOME LDRP UNIT	B	-10	DELIVERY ROOM & LABOR ROOM	52.00	0	33.07
33.08	MISC INCOME PSYCHIATRIC NURSING UNIT	B	-15,337	ADULTS & PEDIATRICS	30.00	0	33.08
33.09	MISC INCOME ONCOLOGY SVS	B	-30,667	CHEMOTHERAPY	76.01	0	33.09
33.10	MISC INCOME ACUTE CARE REHAB	B	-600	SUBPROVIDER - IRF	41.00	0	33.10
33.11	MISC INCOME SOUTHWAY REHAB	B	-5,625	PHYSICAL THERAPY	66.00	0	33.11
33.12	MISC INCOME PERU REHAB	B	-2,715	PHYSICAL THERAPY	66.00	0	33.12
33.13	MISC INCOME FOREST PARK REHAB	B	-18,115	PHYSICAL THERAPY	66.00	0	33.13
33.14	MISC INCOME SURGERY	B	-702	OPERATING ROOM	50.00	0	33.14
33.15	MISC INCOME AMBULANCE	B	-9,266	AMBULANCE SERVICES	95.00	0	33.15
33.16	MISC INCOME RADIOLOGY	B	-2,942	RADIOLOGY-DIAGNOSTIC	54.00	0	33.16
33.17	MISC INCOME MAMMOGRAPHY	B	-6,416	RADIOLOGY-DIAGNOSTIC	54.00	0	33.17
33.18	MISC INCOME LABORATORY	B	-655	LABORATORY	60.00	0	33.18
33.19	MISC INCOME CORPORATE TRANSACTIONS	B	20,702	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	MISC INCOME EMPLOYEE EDUCATION	B	-1,255	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	MISC INCOME HUMAN RESOURCES	B	-225	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.21
33.22	MISC INCOME PLANT OPERATION	B	-1,623	OPERATION OF PLANT	7.00	0	33.22
33.23	MISC INCOME SWITCHBOARD	B	-16,163	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	MISC INCOME SUMMER INTERN PRG	B	-2,100	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	MISC INCOME UNCLAIMED PROPERTY	B	-7,849	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	PROVIDER TAX EXPENSE	A	-8,434,484	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	TELEVISION UTILITIES OFFSET	A	-3,639	OPERATION OF PLANT	7.00	0	33.27
33.28	CHARITABLE DONATIONS OFFSET	A	-11,250	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	MARKETING EXPENSE OFFSET	A	-3,419	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	COROPORATE SPONSORSHIP OFFSET	A	-26,128	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	AHA LIVE OFFSET	A	12,652	CAP REL COSTS-BLDG & FIXT	1.00	9	33.31
33.32	LATE FEES AND PENALTIES OFFSET	A	-1,003	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.32
33.33	REVERSE FY17 STARP TRUE UP	A	50,540	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	REVERSE FY17 STARP FICA TRUE UP	A	18,393	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.34
33.35	LOBBYING EXPENSE	A	-1,139	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	INVESTMENT INCOME CAPITAL	B	-565,323	CAP REL COSTS-BLDG & FIXT	1.00	11	33.36
33.37	INVESTMENT INCOME A&G	B	-7,079	ADMINISTRATIVE & GENERAL	5.00	0	33.37
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,521,648				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/26/2018 12:03 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACK	1,159,114	1,159,114	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACK	83,978	83,978	2.00
3.00	15.00	PHARMACY	SVH CHARGEBACK	-60,468	-60,468	3.00
3.01	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACK	-502	-502	3.01
3.02	23.00	ALLIED HEALTH-RAD TECH PROGR	SVH CHARGEBACK	27,204	27,204	3.02
3.03	31.00	INTENSIVE CARE UNIT	SVH CHARGEBACK	175	175	3.03
4.00	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	75,026	75,026	4.00
4.01	56.00	RADIOISOTOPE	SVH CHARGEBACK	25,908	25,908	4.01
4.02	59.00	CARDIAC CATHETERIZATION	SVH CHARGEBACK	5,000	5,000	4.02
4.03	69.00	ELECTROCARDIOLOGY	SVH CHARGEBACK	10,000	10,000	4.03
4.04	76.01	CHEMOTHERAPY	SVH CHARGEBACK	3,704	3,704	4.04
4.05	91.00	EMERGENCY	SVH CHARGEBACK	175	175	4.05
4.06	192.00	PHYSICIANS' PRIVATE OFFICES	SVH CHARGEBACK	1,850,756	1,850,756	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	SVH MANAGEMENT FEE	25,598,357	25,555,104	4.07
4.08	192.01	MARKETING	SVH MARKETING	598,670	0	4.08
4.09	113.00	INTEREST EXPENSE	SVH INTEREST EXPENSE	565,323	565,323	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	SVH INTEREST EXPENSE	7,079	7,079	4.10
4.11	0.00			0	0	4.11
4.12	0.00			0	0	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			29,949,499	29,307,576	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B		0.00	ASCENSION	100.00	6.00
7.00	B		0.00	SV HEALTH	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/26/2018 12:03 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	43,253	0		4.07
4.08	598,670	0		4.08
4.09	0	11		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
5.00	641,923			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		
6.00	HEALTH MGMT		6.00
7.00	HEALTH MGMT		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/26/2018 12:03 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	DR. A	220,880	148,816	72,064	211,500	721	1.00
2.00	13.00	DR. B	1,675	1,675	0	0	0	2.00
3.00	30.00	DR. C	20,800	20,800	0	0	0	3.00
4.00	76.00	DR. D	216,253	216,253	0	0	0	4.00
5.00	5.00	DR. E	38,200	38,200	0	0	0	5.00
6.00	30.00	DR. F	564,331	564,331	0	0	0	6.00
7.00	56.00	DR. G	126,464	95,838	30,626	271,900	129	7.00
8.00	54.00	DR. H	28,557	15,759	12,798	271,900	149	8.00
9.00	76.00	DR. I	362,300	362,300	0	0	0	9.00
10.00	76.00	DR. J	672	672	0	0	0	10.00
200.00			1,580,132	1,464,644	115,488		999	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	DR. A	73,313	3,666	0	0	0	1.00
2.00	13.00	DR. B	0	0	0	0	0	2.00
3.00	30.00	DR. C	0	0	0	0	0	3.00
4.00	76.00	DR. D	0	0	0	0	0	4.00
5.00	5.00	DR. E	0	0	0	0	0	5.00
6.00	30.00	DR. F	0	0	0	0	0	6.00
7.00	56.00	DR. G	16,863	843	0	0	0	7.00
8.00	54.00	DR. H	19,478	974	0	0	0	8.00
9.00	76.00	DR. I	0	0	0	0	0	9.00
10.00	76.00	DR. J	0	0	0	0	0	10.00
200.00			109,654	5,483	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	DR. A	0	73,313	0	148,816		1.00
2.00	13.00	DR. B	0	0	0	1,675		2.00
3.00	30.00	DR. C	0	0	0	20,800		3.00
4.00	76.00	DR. D	0	0	0	216,253		4.00
5.00	5.00	DR. E	0	0	0	38,200		5.00
6.00	30.00	DR. F	0	0	0	564,331		6.00
7.00	56.00	DR. G	0	16,863	13,763	109,601		7.00
8.00	54.00	DR. H	0	19,478	0	15,759		8.00
9.00	76.00	DR. I	0	0	0	362,300		9.00
10.00	76.00	DR. J	0	0	0	672		10.00
200.00			0	109,654	13,763	1,478,407		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 12:03 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,614,003	2,614,003				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,069,190		2,069,190			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,641,027	101,111	245	8,742,383		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	29,415,817	395,240	8,195	1,108,208	30,927,460	5.00
7.00	00700	OPERATION OF PLANT	4,064,619	362,723	151,077	71,750	4,650,169	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	509,679	4,085	0	0	513,764	8.00
9.00	00900	HOUSEKEEPING	1,674,529	15,892	5,838	0	1,696,259	9.00
10.00	01000	DIETARY	305,012	41,052	10,504	0	356,568	10.00
11.00	01100	CAFETERIA	1,564,184	49,767	20,159	0	1,634,110	11.00
13.00	01300	NURSING ADMINISTRATION	1,747,361	43,071	170,340	380,055	2,340,827	13.00
15.00	01500	PHARMACY	2,032,534	25,231	0	427,268	2,485,033	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,881	19,299	8,015	0	29,195	16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	319,589	7,067	0	75,700	402,356	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,382,847	232,225	142,849	1,358,303	8,116,224	30.00
31.00	03100	INTENSIVE CARE UNIT	1,475,943	44,451	17,911	308,960	1,847,265	31.00
41.00	04100	SUBPROVIDER - IRF	1,143,711	107,011	566	248,302	1,499,590	41.00
43.00	04300	NURSERY	525,402	12,690	17,433	106,802	662,327	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,016,579	257,503	339,925	910,811	7,524,818	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,591,929	25,743	52,822	323,606	1,994,100	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,390,917	187,876	392,069	327,151	3,298,013	54.00
54.01	03630	ULTRA SOUND	388,945	0	7,968	79,141	476,054	54.01
56.00	05600	RADIOISOTOPE	1,086,865	15,774	26,035	179,214	1,307,888	56.00
57.00	05700	CT SCAN	440,024	0	1,902	95,688	537,614	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	330,418	0	0	73,309	403,727	58.00
59.00	05900	CARDIAC CATHETERIZATION	150,984	3,155	16,222	17,204	187,565	59.00
60.00	06000	LABORATORY	5,646,497	62,307	3,103	0	5,711,907	60.00
65.00	06500	RESPIRATORY THERAPY	1,410,256	9,756	54,011	287,126	1,761,149	65.00
66.00	06600	PHYSICAL THERAPY	2,579,895	56,905	38,008	529,747	3,204,555	66.00
67.00	06700	OCCUPATIONAL THERAPY	945,342	24,418	13,588	189,394	1,172,742	67.00
68.00	06800	SPEECH PATHOLOGY	235,646	8,202	3,387	47,211	294,446	68.00
69.00	06900	ELECTROCARDIOLOGY	758,832	31,572	149,871	161,438	1,101,713	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	593,688	21,516	25,080	98,736	739,020	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,536,861	33,985	80,077	68,747	1,719,670	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,926,467	0	0	0	2,926,467	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,887,111	0	0	0	15,887,111	73.00
74.00	07400	RENAL DIALYSIS	276,082	0	0	0	276,082	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,227,997	36,209	0	326,201	1,590,407	76.00
76.01	03190	CHEMOTHERAPY	4,962,246	0	0	117,479	5,079,725	76.01
76.02	03330	ENDOSCOPY	211,703	0	79,162	22,537	313,402	76.02
76.03	03950	WOUND CARE CENTER	801,986	23,661	7,652	55,204	888,503	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,185,784	152,535	72,278	463,085	2,873,682	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	921,677	31,296	139,679	190,296	1,282,948	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	119,992,059	2,443,328	2,055,971	8,648,673	119,714,455	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,116	0	0	8,116	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,976,329	161,139	12,511	17,890	2,167,869	192.00
192.01	19201	MARKETING	598,981	0	0	0	598,981	192.01
192.02	19202	EDUCATION CENTER	20,716	0	0	0	20,716	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	1,420	97	0	1,517	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	8,460	0	0	0	8,460	194.01
194.02	07952	CLINIC OF HOPE	371,766	0	611	75,820	448,197	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	122,968,311	2,614,003	2,069,190	8,742,383	122,968,311	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 12:03 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,927,460					5.00
7.00	00700	OPERATION OF PLANT	1,562,545	6,212,714				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	172,634	14,463	700,861			8.00
9.00	00900	HOUSEKEEPING	569,975	56,261	217,842	2,540,337		9.00
10.00	01000	DIETARY	119,814	145,330	0	0	621,712	10.00
11.00	01100	CAFETERIA	549,092	176,183	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	786,562	152,478	0	1,945	0	13.00
15.00	01500	PHARMACY	835,018	89,320	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,810	68,323	0	648	0	16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	135,199	25,017	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,727,205	822,111	226,572	795,439	411,739	30.00
31.00	03100	INTENSIVE CARE UNIT	620,716	157,364	55,367	194,513	50,588	31.00
41.00	04100	SUBPROVIDER - IRF	503,891	378,835	22,065	194,513	99,026	41.00
43.00	04300	NURSERY	222,554	44,925	9,266	107,008	60,359	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,528,482	911,599	7,098	389,026	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	670,055	91,135	25,120	206,274	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,108,195	665,110	15,693	39,551	0	54.00
54.01	03630	ULTRA SOUND	159,963	0	2,885	8,429	0	54.01
56.00	05600	RADIOISOTOPE	439,475	55,842	0	29,177	0	56.00
57.00	05700	CT SCAN	180,649	0	5,653	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	135,660	0	1,363	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	63,025	11,168	0	12,968	0	59.00
60.00	06000	LABORATORY	1,919,309	220,577	523	80,399	0	60.00
65.00	06500	RESPIRATORY THERAPY	591,780	34,539	481	3,890	0	65.00
66.00	06600	PHYSICAL THERAPY	1,076,791	201,451	0	8,961	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	394,064	86,444	0	4,500	0	67.00
68.00	06800	SPEECH PATHOLOGY	98,939	29,038	444	9,233	0	68.00
69.00	06900	ELECTROCARDIOLOGY	370,197	111,768	0	5,187	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	248,325	76,169	0	33,067	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	577,842	120,312	15,827	72,618	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	983,349	0	49	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,338,357	0	79	29,177	0	73.00
74.00	07400	RENAL DIALYSIS	92,769	0	0	12,968	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	534,407	128,186	0	25,935	0	76.00
76.01	03190	CHEMOTHERAPY	1,706,884	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	105,309	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	298,554	83,764	0	41,496	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	965,612	539,996	85,278	233,415	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	431,095	110,791	9,256	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,834,102	5,608,499	700,861	2,540,337	621,712	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,727	28,731	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	728,445	570,458	0	0	0	192.00
192.01	19201	MARKETING	201,269	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	6,961	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	510	5,026	0	0	0	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	2,843	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	150,603	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	30,927,460	6,212,714	700,861	2,540,337	621,712	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 12:03 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	ALLIED HEALTH-RAD TECH PROGRAM	
			11.00	13.00	15.00	16.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,359,385					11.00
13.00	01300	NURSING ADMINISTRATION	99,242	3,381,054				13.00
15.00	01500	PHARMACY	97,037	0	3,506,408			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	107,976		16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	22,717	0	0	0	585,289	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	457,096	1,218,125	0	6,112	0	30.00
31.00	03100	INTENSIVE CARE UNIT	89,412	238,275	0	1,491	0	31.00
41.00	04100	SUBPROVIDER - IRF	82,818	220,703	0	1,253	0	41.00
43.00	04300	NURSERY	32,800	87,409	0	835	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	290,039	772,931	0	17,843	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	99,382	264,845	0	2,802	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	112,748	0	0	5,094	218,444	54.00
54.01	03630	ULTRA SOUND	18,802	0	0	1,706	73,190	54.01
56.00	05600	RADIOISOTOPE	44,543	0	0	4,015	172,193	56.00
57.00	05700	CT SCAN	24,730	0	0	2,223	95,322	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	21,688	0	0	609	26,140	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,609	12,283	0	372	0	59.00
60.00	06000	LABORATORY	0	0	0	14,246	0	60.00
65.00	06500	RESPIRATORY THERAPY	85,760	0	0	2,523	0	65.00
66.00	06600	PHYSICAL THERAPY	155,901	0	0	2,892	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	55,736	0	0	955	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,893	0	0	211	0	68.00
69.00	06900	ELECTROCARDIOLOGY	49,184	0	0	3,040	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	33,661	0	0	1,403	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,848	0	0	3,087	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,699	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,503,246	11,920	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	52	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	105,938	0	0	1,116	0	76.00
76.01	03190	CHEMOTHERAPY	42,521	113,315	0	1,044	0	76.01
76.02	03330	ENDOSCOPY	5,422	14,449	0	629	0	76.02
76.03	03950	WOUND CARE CENTER	21,436	57,126	0	2,970	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	143,191	381,593	0	13,077	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	90,108	0	0	1,757	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,334,262	3,381,054	3,503,246	107,976	585,289	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,731	0	0	0	0	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	21,392	0	3,162	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,359,385	3,381,054	3,506,408	107,976	585,289	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/26/2018 12:03 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	14,780,623	0	14,780,623		30.00
31.00	03100	INTENSIVE CARE UNIT	3,254,991	0	3,254,991		31.00
41.00	04100	SUBPROVIDER - IRF	3,002,694	0	3,002,694		41.00
43.00	04300	NURSERY	1,227,483	0	1,227,483		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	12,441,836	0	12,441,836		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,353,713	0	3,353,713		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,462,848	0	5,462,848		54.00
54.01	03630	ULTRA SOUND	741,029	0	741,029		54.01
56.00	05600	RADIOISOTOPE	2,053,133	0	2,053,133		56.00
57.00	05700	CT SCAN	846,191	0	846,191		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	589,187	0	589,187		58.00
59.00	05900	CARDIAC CATHETERIZATION	291,990	0	291,990		59.00
60.00	06000	LABORATORY	7,946,961	0	7,946,961		60.00
65.00	06500	RESPIRATORY THERAPY	2,480,122	0	2,480,122		65.00
66.00	06600	PHYSICAL THERAPY	4,650,551	0	4,650,551		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,714,441	0	1,714,441		67.00
68.00	06800	SPEECH PATHOLOGY	446,204	0	446,204		68.00
69.00	06900	ELECTROCARDIOLOGY	1,641,089	0	1,641,089		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,131,645	0	1,131,645		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,543,204	0	2,543,204		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,912,564	0	3,912,564		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,769,890	0	24,769,890		73.00
74.00	07400	RENAL DIALYSIS	381,871	0	381,871		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,385,989	0	2,385,989		76.00
76.01	03190	CHEMOTHERAPY	6,943,489	0	6,943,489		76.01
76.02	03330	ENDOSCOPY	439,211	0	439,211		76.02
76.03	03950	WOUND CARE CENTER	1,393,849	0	1,393,849		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	5,235,844	0	5,235,844		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,925,955	0	1,925,955		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	117,988,597	0	117,988,597		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	39,574	0	39,574		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,470,503	0	3,470,503		192.00
192.01	19201	MARKETING	800,250	0	800,250		192.01
192.02	19202	EDUCATION CENTER	27,677	0	27,677		192.02
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	FOUNDATION	7,053	0	7,053		194.00
194.01	07951	ASPR BIOTERRORISM GRANT	11,303	0	11,303		194.01
194.02	07952	CLINIC OF HOPE	623,354	0	623,354		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	122,968,311	0	122,968,311		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 12:03 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	101,111	245	101,356	101,356	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,108,423	395,240	8,195	2,511,858	12,850	5.00
7.00	00700	OPERATION OF PLANT	0	362,723	151,077	513,800	832	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,085	0	4,085	0	8.00
9.00	00900	HOUSEKEEPING	0	15,892	5,838	21,730	0	9.00
10.00	01000	DIETARY	0	41,052	10,504	51,556	0	10.00
11.00	01100	CAFETERIA	0	49,767	20,159	69,926	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	43,071	170,340	213,411	4,407	13.00
15.00	01500	PHARMACY	0	25,231	0	25,231	4,954	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,299	8,015	27,314	0	16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	0	7,067	0	7,067	878	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	232,225	142,849	375,074	15,738	30.00
31.00	03100	INTENSIVE CARE UNIT	0	44,451	17,911	62,362	3,582	31.00
41.00	04100	SUBPROVIDER - IRF	0	107,011	566	107,577	2,879	41.00
43.00	04300	NURSERY	0	12,690	17,433	30,123	1,238	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	257,503	339,925	597,428	10,561	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	25,743	52,822	78,565	3,752	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	187,876	392,069	579,945	3,793	54.00
54.01	03630	ULTRA SOUND	0	0	7,968	7,968	918	54.01
56.00	05600	RADIOISOTOPE	0	15,774	26,035	41,809	2,078	56.00
57.00	05700	CT SCAN	0	0	1,902	1,902	1,110	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	850	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,155	16,222	19,377	199	59.00
60.00	06000	LABORATORY	0	62,307	3,103	65,410	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,756	54,011	63,767	3,329	65.00
66.00	06600	PHYSICAL THERAPY	0	56,905	38,008	94,913	6,143	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	24,418	13,588	38,006	2,196	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,202	3,387	11,589	547	68.00
69.00	06900	ELECTROCARDIOLOGY	0	31,572	149,871	181,443	1,872	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	21,516	25,080	46,596	1,145	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	33,985	80,077	114,062	797	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	36,209	0	36,209	3,782	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	1,362	76.01
76.02	03330	ENDOSCOPY	0	0	79,162	79,162	261	76.02
76.03	03950	WOUND CARE CENTER	0	23,661	7,652	31,313	640	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	152,535	72,278	224,813	5,370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	31,296	139,679	170,975	2,207	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,108,423	2,443,328	2,055,971	6,607,722	100,270	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,116	0	8,116	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	161,139	12,511	173,650	207	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	1,420	97	1,517	0	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	0	0	611	611	879	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,108,423	2,614,003	2,069,190	6,791,616	101,356	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/26/2018 12:03 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,524,708					5.00
7.00	00700	OPERATION OF PLANT	127,554	642,186				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,093	1,495	19,673			8.00
9.00	00900	HOUSEKEEPING	46,528	5,816	6,115	80,189		9.00
10.00	01000	DIETARY	9,781	15,022	0	0	76,359	10.00
11.00	01100	CAFETERIA	44,824	18,211	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	64,209	15,761	0	61	0	13.00
15.00	01500	PHARMACY	68,164	9,233	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	801	7,062	0	20	0	16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	11,037	2,586	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	222,628	84,979	6,362	25,111	50,571	30.00
31.00	03100	INTENSIVE CARE UNIT	50,670	16,266	1,554	6,140	6,213	31.00
41.00	04100	SUBPROVIDER - IRF	41,134	39,159	619	6,140	12,162	41.00
43.00	04300	NURSERY	18,168	4,644	260	3,378	7,413	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	206,406	94,231	199	12,280	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	54,698	9,420	705	6,511	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,464	68,750	440	1,248	0	54.00
54.01	03630	ULTRA SOUND	13,058	0	81	266	0	54.01
56.00	05600	RADIOISOTOPE	35,875	5,772	0	921	0	56.00
57.00	05700	CT SCAN	14,747	0	159	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,074	0	38	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,145	1,154	0	409	0	59.00
60.00	06000	LABORATORY	156,678	22,800	15	2,538	0	60.00
65.00	06500	RESPIRATORY THERAPY	48,308	3,570	13	123	0	65.00
66.00	06600	PHYSICAL THERAPY	87,901	20,823	0	283	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,168	8,935	0	142	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,077	3,002	12	291	0	68.00
69.00	06900	ELECTROCARDIOLOGY	30,220	11,553	0	164	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,271	7,873	0	1,044	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,171	12,436	444	2,292	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,273	0	1	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	435,809	0	2	921	0	73.00
74.00	07400	RENAL DIALYSIS	7,573	0	0	409	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	43,625	13,250	0	819	0	76.00
76.01	03190	CHEMOTHERAPY	139,337	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	8,597	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	24,372	8,658	0	1,310	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	78,825	55,817	2,394	7,368	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	35,191	11,452	260	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,435,454	579,730	19,673	80,189	76,359	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	223	2,970	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,465	58,966	0	0	0	192.00
192.01	19201	MARKETING	16,430	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	568	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	42	520	0	0	0	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	232	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	12,294	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,524,708	642,186	19,673	80,189	76,359	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/26/2018 12:03 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	ALLIED HEALTH-RAD TECH PROGRAM	
			11.00	13.00	15.00	16.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	132,961					11.00
13.00	01300	NURSING ADMINISTRATION	5,593	303,442				13.00
15.00	01500	PHARMACY	5,468	0	113,050			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	35,197		16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	1,280	0	0	0	22,848	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,758	109,323	0	1,998		30.00
31.00	03100	INTENSIVE CARE UNIT	5,039	21,385	0	487		31.00
41.00	04100	SUBPROVIDER - IRF	4,667	19,808	0	409		41.00
43.00	04300	NURSERY	1,848	7,845	0	273		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,345	69,369	0	5,731		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,601	23,769	0	916		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,354	0	0	1,665		54.00
54.01	03630	ULTRA SOUND	1,060	0	0	558		54.01
56.00	05600	RADIOISOTOPE	2,510	0	0	1,313		56.00
57.00	05700	CT SCAN	1,394	0	0	727		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,222	0	0	199		58.00
59.00	05900	CARDIAC CATHETERIZATION	260	1,102	0	122		59.00
60.00	06000	LABORATORY	0	0	0	4,657		60.00
65.00	06500	RESPIRATORY THERAPY	4,833	0	0	825		65.00
66.00	06600	PHYSICAL THERAPY	8,786	0	0	946		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,141	0	0	312		67.00
68.00	06800	SPEECH PATHOLOGY	783	0	0	69		68.00
69.00	06900	ELECTROCARDIOLOGY	2,772	0	0	994		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,897	0	0	459		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,907	0	0	1,009		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	882		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	112,948	3,897		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	17		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,970	0	0	365		76.00
76.01	03190	CHEMOTHERAPY	2,396	10,170	0	341		76.01
76.02	03330	ENDOSCOPY	306	1,297	0	206		76.02
76.03	03950	WOUND CARE CENTER	1,208	5,127	0	971		76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,069	34,247	0	4,275		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,078	0	0	574		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	131,545	303,442	112,948	35,197	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	210	0	0	0		192.00
192.01	19201	MARKETING	0	0	0	0		192.01
192.02	19202	EDUCATION CENTER	0	0	0	0		192.02
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	FOUNDATION	0	0	0	0		194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0		194.01
194.02	07952	CLINIC OF HOPE	1,206	0	102	0		194.02
200.00		Cross Foot Adjustments					22,848	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	132,961	303,442	113,050	35,197	22,848	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/26/2018 12:03 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	917,542	0	917,542		30.00
31.00	03100	INTENSIVE CARE UNIT	173,698	0	173,698		31.00
41.00	04100	SUBPROVIDER - IRF	234,554	0	234,554		41.00
43.00	04300	NURSERY	75,190	0	75,190		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,012,550	0	1,012,550		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	183,937	0	183,937		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	752,659	0	752,659		54.00
54.01	03630	ULTRA SOUND	23,909	0	23,909		54.01
56.00	05600	RADIOISOTOPE	90,278	0	90,278		56.00
57.00	05700	CT SCAN	20,039	0	20,039		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,383	0	13,383		58.00
59.00	05900	CARDIAC CATHETERIZATION	27,768	0	27,768		59.00
60.00	06000	LABORATORY	252,098	0	252,098		60.00
65.00	06500	RESPIRATORY THERAPY	124,768	0	124,768		65.00
66.00	06600	PHYSICAL THERAPY	219,795	0	219,795		66.00
67.00	06700	OCCUPATIONAL THERAPY	84,900	0	84,900		67.00
68.00	06800	SPEECH PATHOLOGY	24,370	0	24,370		68.00
69.00	06900	ELECTROCARDIOLOGY	229,018	0	229,018		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	79,285	0	79,285		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	180,118	0	180,118		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	81,156	0	81,156		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	553,577	0	553,577		73.00
74.00	07400	RENAL DIALYSIS	7,999	0	7,999		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	104,020	0	104,020		76.00
76.01	03190	CHEMOTHERAPY	153,606	0	153,606		76.01
76.02	03330	ENDOSCOPY	89,829	0	89,829		76.02
76.03	03950	WOUND CARE CENTER	73,599	0	73,599		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	421,178	0	421,178		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	225,737	0	225,737		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,430,560	0	6,430,560		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,309	0	11,309		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	292,498	0	292,498		192.00
192.01	19201	MARKETING	16,430	0	16,430		192.01
192.02	19202	EDUCATION CENTER	568	0	568		192.02
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	FOUNDATION	2,079	0	2,079		194.00
194.01	07951	ASPR BIOTERRORISM GRANT	232	0	232		194.01
194.02	07952	CLINIC OF HOPE	15,092	0	15,092		194.02
200.00		Cross Foot Adjustments	22,848	0	22,848		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	6,791,616	0	6,791,616		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 12:03 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	331,432					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,689,841				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,820	200	35,656,036			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	50,113	6,693	4,519,849	-30,927,460	92,040,851	5.00
7.00	00700	OPERATION OF PLANT	45,990	123,380	292,632	0	4,650,169	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	518	0	0	0	513,764	8.00
9.00	00900	HOUSEKEEPING	2,015	4,768	0	0	1,696,259	9.00
10.00	01000	DIETARY	5,205	8,578	0	0	356,568	10.00
11.00	01100	CAFETERIA	6,310	16,463	0	0	1,634,110	11.00
13.00	01300	NURSING ADMINISTRATION	5,461	139,111	1,550,060	0	2,340,827	13.00
15.00	01500	PHARMACY	3,199	0	1,742,622	0	2,485,033	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,447	6,546	0	0	29,195	16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	896	0	308,745	0	402,356	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,444	116,660	5,539,913	0	8,116,224	30.00
31.00	03100	INTENSIVE CARE UNIT	5,636	14,627	1,260,101	0	1,847,265	31.00
41.00	04100	SUBPROVIDER - IRF	13,568	462	1,012,706	0	1,499,590	41.00
43.00	04300	NURSERY	1,609	14,237	435,596	0	662,327	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,649	277,606	3,714,760	0	7,524,818	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,264	43,138	1,319,833	0	1,994,100	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,821	320,192	1,334,292	0	3,298,013	54.00
54.01	03630	ULTRA SOUND	0	6,507	322,778	0	476,054	54.01
56.00	05600	RADIOISOTOPE	2,000	21,262	730,929	0	1,307,888	56.00
57.00	05700	CT SCAN	0	1,553	390,264	0	537,614	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	298,992	0	403,727	58.00
59.00	05900	CARDIAC CATHETERIZATION	400	13,248	70,165	0	187,565	59.00
60.00	06000	LABORATORY	7,900	2,534	0	0	5,711,907	60.00
65.00	06500	RESPIRATORY THERAPY	1,237	44,109	1,171,050	0	1,761,149	65.00
66.00	06600	PHYSICAL THERAPY	7,215	31,040	2,160,584	0	3,204,555	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,096	11,097	772,449	0	1,172,742	67.00
68.00	06800	SPEECH PATHOLOGY	1,040	2,766	192,549	0	294,446	68.00
69.00	06900	ELECTROCARDIOLOGY	4,003	122,395	658,428	0	1,101,713	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,728	20,482	402,697	0	739,020	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	65,396	280,388	0	1,719,670	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,926,467	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	15,887,111	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	276,082	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,591	0	1,330,419	0	1,590,407	76.00
76.01	03190	CHEMOTHERAPY	0	0	479,139	0	5,079,725	76.01
76.02	03330	ENDOSCOPY	0	64,649	91,919	0	313,402	76.02
76.03	03950	WOUND CARE CENTER	3,000	6,249	225,151	0	888,503	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	19,340	59,027	1,888,701	0	2,873,682	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,968	114,071	776,126	0	1,282,948	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	309,792	1,679,046	35,273,837	-30,927,460	88,786,995	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,029	0	0	0	8,116	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,431	10,217	72,966	0	2,167,869	192.00
192.01	19201	MARKETING	0	0	0	0	598,981	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	20,716	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	180	79	0	0	1,517	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	8,460	194.01
194.02	07952	CLINIC OF HOPE	0	499	309,233	0	448,197	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,614,003	2,069,190	8,742,383		30,927,460	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.886996	1.224488	0.245187		0.336019	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			101,356		2,524,708	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 12:03 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002843		0.027430	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 12:03 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MANHOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	222,509					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	518	497,077				8.00
9.00	00900	HOUSEKEEPING	2,015	154,502	195,900			9.00
10.00	01000	DIETARY	5,205	0	0	22,269		10.00
11.00	01100	CAFETERIA	6,310	0	0	0	1,013,033	11.00
13.00	01300	NURSING ADMINISTRATION	5,461	0	150	0	42,611	13.00
15.00	01500	PHARMACY	3,199	0	0	0	41,664	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,447	0	50	0	0	16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	896	0	0	0	9,754	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,444	160,694	61,341	14,748	196,260	30.00
31.00	03100	INTENSIVE CARE UNIT	5,636	39,268	15,000	1,812	38,390	31.00
41.00	04100	SUBPROVIDER - IRF	13,568	15,649	15,000	3,547	35,559	41.00
43.00	04300	NURSERY	1,609	6,572	8,252	2,162	14,083	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,649	5,034	30,000	0	124,532	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,264	17,816	15,907	0	42,671	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,821	11,130	3,050	0	48,410	54.00
54.01	03630	ULTRA SOUND	0	2,046	650	0	8,073	54.01
56.00	05600	RADIOISOTOPE	2,000	0	2,250	0	19,125	56.00
57.00	05700	CT SCAN	0	4,009	0	0	10,618	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	967	0	0	9,312	58.00
59.00	05900	CARDIAC CATHETERIZATION	400	0	1,000	0	1,979	59.00
60.00	06000	LABORATORY	7,900	371	6,200	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,237	341	300	0	36,822	65.00
66.00	06600	PHYSICAL THERAPY	7,215	0	691	0	66,938	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,096	0	347	0	23,931	67.00
68.00	06800	SPEECH PATHOLOGY	1,040	315	712	0	5,965	68.00
69.00	06900	ELECTROCARDIOLOGY	4,003	0	400	0	21,118	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,728	0	2,550	0	14,453	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	11,225	5,600	0	14,533	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	35	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	56	2,250	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,000	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,591	0	2,000	0	45,486	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	18,257	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	2,328	76.02
76.03	03950	WOUND CARE CENTER	3,000	0	3,200	0	9,204	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	19,340	60,482	18,000	0	61,481	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,968	6,565	0	0	38,689	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	200,869	497,077	195,900	22,269	1,002,246	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,029	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,431	0	0	0	1,602	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	180	0	0	0	0	194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	0	0	0	0	9,185	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,212,714	700,861	2,540,337	621,712	2,359,385	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.921181	1.409965	12.967519	27.918272	2.329031	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	642,186	19,673	80,189	76,359	132,961	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.886112	0.039577	0.409336	3.428937	0.131250	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 12:03 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MANHOURS)	
			7.00	8.00	9.00	10.00	11.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 12:03 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH-RAD TECH PROGRAM (RADIOLOGY CHARGES)		
			13.00	15.00	16.00	23.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	544,744					13.00
15.00	01500	PHARMACY	0	4,388,682				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	518,872,850			16.00
23.00	02300	ALLIED HEALTH-RAD TECH PROGRAM	0	0	0	65,611,647		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	196,260	0	29,386,057	0		30.00
31.00	03100	INTENSIVE CARE UNIT	38,390	0	7,168,994	0		31.00
41.00	04100	SUBPROVIDER - IRF	35,559	0	6,022,023	0		41.00
43.00	04300	NURSERY	14,083	0	4,012,318	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	124,532	0	85,536,282	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	42,671	0	13,471,098	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	24,490,166	24,490,167		54.00
54.01	03630	ULTRA SOUND	0	0	8,204,204	8,204,204		54.01
56.00	05600	RADIOISOTOPE	0	0	19,302,004	19,302,004		56.00
57.00	05700	CT SCAN	0	0	10,685,097	10,685,098		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	2,930,175	2,930,174		58.00
59.00	05900	CARDIAC CATHETERIZATION	1,979	0	1,787,397	0		59.00
60.00	06000	LABORATORY	0	0	68,490,956	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	12,130,031	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	13,904,695	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	4,589,508	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,014,272	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	14,616,280	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	6,744,909	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	14,842,764	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	12,974,948	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,384,725	57,308,686	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	252,117	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	5,364,054	0		76.00
76.01	03190	CHEMOTHERAPY	18,257	0	5,021,049	0		76.01
76.02	03330	ENDOSCOPY	2,328	0	3,026,209	0		76.02
76.03	03950	WOUND CARE CENTER	9,204	0	14,279,671	0		76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	61,481	0	62,871,417	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	8,445,469	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	544,744	4,384,725	518,872,850	65,611,647		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	MARKETING	0	0	0	0		192.01
192.02	19202	EDUCATION CENTER	0	0	0	0		192.02
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	FOUNDATION	0	0	0	0		194.00
194.01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0		194.01
194.02	07952	CLINIC OF HOPE	0	3,957	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,381,054	3,506,408	107,976	585,289		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.206684	0.798966	0.000208	0.008921		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	303,442	113,050	35,197	22,848		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.557036	0.025759	0.000068	0.000348		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/26/2018 12:03 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH-RAD TECH PROGRAM (RADIOLOGY CHARGES)		
			13.00	15.00	16.00	23.00		
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 12:03 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,780,623		14,780,623	0	14,780,623	30.00
31.00	03100	INTENSIVE CARE UNIT	3,254,991		3,254,991	0	3,254,991	31.00
41.00	04100	SUBPROVIDER - IRF	3,002,694		3,002,694	0	3,002,694	41.00
43.00	04300	NURSERY	1,227,483		1,227,483	0	1,227,483	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,441,836		12,441,836	0	12,441,836	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,353,713		3,353,713	0	3,353,713	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,462,848		5,462,848	0	5,462,848	54.00
54.01	03630	ULTRA SOUND	741,029		741,029	0	741,029	54.01
56.00	05600	RADIOISOTOPE	2,053,133		2,053,133	13,763	2,066,896	56.00
57.00	05700	CT SCAN	846,191		846,191	0	846,191	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	589,187		589,187	0	589,187	58.00
59.00	05900	CARDIAC CATHETERIZATION	291,990		291,990	0	291,990	59.00
60.00	06000	LABORATORY	7,946,961		7,946,961	0	7,946,961	60.00
65.00	06500	RESPIRATORY THERAPY	2,480,122	0	2,480,122	0	2,480,122	65.00
66.00	06600	PHYSICAL THERAPY	4,650,551	0	4,650,551	0	4,650,551	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,714,441	0	1,714,441	0	1,714,441	67.00
68.00	06800	SPEECH PATHOLOGY	446,204	0	446,204	0	446,204	68.00
69.00	06900	ELECTROCARDIOLOGY	1,641,089		1,641,089	0	1,641,089	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,131,645		1,131,645	0	1,131,645	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,543,204		2,543,204	0	2,543,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,912,564		3,912,564	0	3,912,564	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,769,890		24,769,890	0	24,769,890	73.00
74.00	07400	RENAL DIALYSIS	381,871		381,871	0	381,871	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,385,989		2,385,989	0	2,385,989	76.00
76.01	03190	CHEMOTHERAPY	6,943,489		6,943,489	0	6,943,489	76.01
76.02	03330	ENDOSCOPY	439,211		439,211	0	439,211	76.02
76.03	03950	WOUND CARE CENTER	1,393,849		1,393,849	0	1,393,849	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,235,844		5,235,844	0	5,235,844	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	965,769		965,769		965,769	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,925,955		1,925,955	0	1,925,955	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	118,954,366	0	118,954,366	13,763	118,968,129	200.00
201.00		Less Observation Beds	965,769		965,769		965,769	201.00
202.00		Total (see instructions)	117,988,597	0	117,988,597	13,763	118,002,360	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 12:03 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,077,483		27,077,483			30.00
31.00	03100	INTENSIVE CARE UNIT	7,168,994		7,168,994			31.00
41.00	04100	SUBPROVIDER - IRF	6,022,023		6,022,023			41.00
43.00	04300	NURSERY	4,012,318		4,012,318			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,223,285	58,312,997	85,536,282	0.145457	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,182,098	1,289,000	13,471,098	0.248956	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,939,115	21,551,051	24,490,166	0.223063	0.000000	54.00
54.01	03630	ULTRA SOUND	1,226,521	6,977,683	8,204,204	0.090323	0.000000	54.01
56.00	05600	RADIOISOTOPE	310,405	18,991,599	19,302,004	0.106369	0.000000	56.00
57.00	05700	CT SCAN	2,244,711	8,440,386	10,685,097	0.079194	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	563,751	2,366,424	2,930,175	0.201076	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	475,281	1,312,116	1,787,397	0.163360	0.000000	59.00
60.00	06000	LABORATORY	24,770,993	43,719,963	68,490,956	0.116029	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,361,343	3,768,688	12,130,031	0.204461	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,746,809	10,157,886	13,904,695	0.334459	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,871,519	1,717,989	4,589,508	0.373557	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	563,804	450,468	1,014,272	0.439925	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,508,496	12,107,784	14,616,280	0.112278	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	200,110	6,544,799	6,744,909	0.167778	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,471,178	6,371,586	14,842,764	0.171343	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,509,520	4,465,428	12,974,948	0.301548	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,031,722	46,276,964	57,308,686	0.432219	0.000000	73.00
74.00	07400	RENAL DIALYSIS	252,117	0	252,117	1.514658	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	21,177	5,342,877	5,364,054	0.444811	0.000000	76.00
76.01	03190	CHEMOTHERAPY	143,762	4,877,287	5,021,049	1.382876	0.000000	76.01
76.02	03330	ENDOSCOPY	273,887	2,752,322	3,026,209	0.145136	0.000000	76.02
76.03	03950	WOUND CARE CENTER	161,971	14,117,700	14,279,671	0.097611	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,874,065	51,997,352	62,871,417	0.083279	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	388,400	1,920,174	2,308,574	0.418340	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	8,445,469	8,445,469	0.228046	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	174,596,858	344,275,992	518,872,850			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	174,596,858	344,275,992	518,872,850			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 12:03 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.145457	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.248956	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223063	54.00
54.01	03630	ULTRA SOUND	0.090323	54.01
56.00	05600	RADIOISOTOPE	0.107082	56.00
57.00	05700	CT SCAN	0.079194	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.201076	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.163360	59.00
60.00	06000	LABORATORY	0.116029	60.00
65.00	06500	RESPIRATORY THERAPY	0.204461	65.00
66.00	06600	PHYSICAL THERAPY	0.334459	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373557	67.00
68.00	06800	SPEECH PATHOLOGY	0.439925	68.00
69.00	06900	ELECTROCARDIOLOGY	0.112278	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.167778	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.171343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.301548	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.432219	73.00
74.00	07400	RENAL DIALYSIS	1.514658	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.444811	76.00
76.01	03190	CHEMOTHERAPY	1.382876	76.01
76.02	03330	ENDOSCOPY	0.145136	76.02
76.03	03950	WOUND CARE CENTER	0.097611	76.03
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.083279	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.418340	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.228046	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 12:03 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,780,623		14,780,623	0	14,780,623	30.00
31.00	03100	INTENSIVE CARE UNIT	3,254,991		3,254,991	0	3,254,991	31.00
41.00	04100	SUBPROVIDER - IRF	3,002,694		3,002,694	0	3,002,694	41.00
43.00	04300	NURSERY	1,227,483		1,227,483	0	1,227,483	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,441,836		12,441,836	0	12,441,836	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,353,713		3,353,713	0	3,353,713	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,462,848		5,462,848	0	5,462,848	54.00
54.01	03630	ULTRA SOUND	741,029		741,029	0	741,029	54.01
56.00	05600	RADIOISOTOPE	2,053,133		2,053,133	13,763	2,066,896	56.00
57.00	05700	CT SCAN	846,191		846,191	0	846,191	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	589,187		589,187	0	589,187	58.00
59.00	05900	CARDIAC CATHETERIZATION	291,990		291,990	0	291,990	59.00
60.00	06000	LABORATORY	7,946,961		7,946,961	0	7,946,961	60.00
65.00	06500	RESPIRATORY THERAPY	2,480,122	0	2,480,122	0	2,480,122	65.00
66.00	06600	PHYSICAL THERAPY	4,650,551	0	4,650,551	0	4,650,551	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,714,441	0	1,714,441	0	1,714,441	67.00
68.00	06800	SPEECH PATHOLOGY	446,204	0	446,204	0	446,204	68.00
69.00	06900	ELECTROCARDIOLOGY	1,641,089		1,641,089	0	1,641,089	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,131,645		1,131,645	0	1,131,645	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,543,204		2,543,204	0	2,543,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,912,564		3,912,564	0	3,912,564	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,769,890		24,769,890	0	24,769,890	73.00
74.00	07400	RENAL DIALYSIS	381,871		381,871	0	381,871	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,385,989		2,385,989	0	2,385,989	76.00
76.01	03190	CHEMOTHERAPY	6,943,489		6,943,489	0	6,943,489	76.01
76.02	03330	ENDOSCOPY	439,211		439,211	0	439,211	76.02
76.03	03950	WOUND CARE CENTER	1,393,849		1,393,849	0	1,393,849	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,235,844		5,235,844	0	5,235,844	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	965,769		965,769		965,769	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,925,955		1,925,955	0	1,925,955	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	118,954,366	0	118,954,366	13,763	118,968,129	200.00
201.00		Less Observation Beds	965,769		965,769		965,769	201.00
202.00		Total (see instructions)	117,988,597	0	117,988,597	13,763	118,002,360	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 12:03 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,077,483		27,077,483			30.00
31.00	03100	INTENSIVE CARE UNIT	7,168,994		7,168,994			31.00
41.00	04100	SUBPROVIDER - IRF	6,022,023		6,022,023			41.00
43.00	04300	NURSERY	4,012,318		4,012,318			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,223,285	58,312,997	85,536,282	0.145457	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,182,098	1,289,000	13,471,098	0.248956	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,939,115	21,551,051	24,490,166	0.223063	0.000000	54.00
54.01	03630	ULTRA SOUND	1,226,521	6,977,683	8,204,204	0.090323	0.000000	54.01
56.00	05600	RADIOISOTOPE	310,405	18,991,599	19,302,004	0.106369	0.000000	56.00
57.00	05700	CT SCAN	2,244,711	8,440,386	10,685,097	0.079194	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	563,751	2,366,424	2,930,175	0.201076	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	475,281	1,312,116	1,787,397	0.163360	0.000000	59.00
60.00	06000	LABORATORY	24,770,993	43,719,963	68,490,956	0.116029	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,361,343	3,768,688	12,130,031	0.204461	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,746,809	10,157,886	13,904,695	0.334459	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,871,519	1,717,989	4,589,508	0.373557	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	563,804	450,468	1,014,272	0.439925	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,508,496	12,107,784	14,616,280	0.112278	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	200,110	6,544,799	6,744,909	0.167778	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,471,178	6,371,586	14,842,764	0.171343	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,509,520	4,465,428	12,974,948	0.301548	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,031,722	46,276,964	57,308,686	0.432219	0.000000	73.00
74.00	07400	RENAL DIALYSIS	252,117	0	252,117	1.514658	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	21,177	5,342,877	5,364,054	0.444811	0.000000	76.00
76.01	03190	CHEMOTHERAPY	143,762	4,877,287	5,021,049	1.382876	0.000000	76.01
76.02	03330	ENDOSCOPY	273,887	2,752,322	3,026,209	0.145136	0.000000	76.02
76.03	03950	WOUND CARE CENTER	161,971	14,117,700	14,279,671	0.097611	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,874,065	51,997,352	62,871,417	0.083279	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	388,400	1,920,174	2,308,574	0.418340	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	8,445,469	8,445,469	0.228046	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	174,596,858	344,275,992	518,872,850			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	174,596,858	344,275,992	518,872,850			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/26/2018 12:03 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.00
76.01	03190	CHEMOTHERAPY	0.000000	76.01
76.02	03330	ENDOSCOPY	0.000000	76.02
76.03	03950	WOUND CARE CENTER	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part I Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	917,542	0	917,542	15,779	58.15	30.00
31.00	INTENSIVE CARE UNIT	173,698		173,698	1,812	95.86	31.00
41.00	SUBPROVIDER - IRF	234,554	0	234,554	3,547	66.13	41.00
43.00	NURSERY	75,190		75,190	2,162	34.78	43.00
200.00	Total (lines 30 through 199)	1,400,984		1,400,984	23,300		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	5,581	324,535	30.00
31.00	INTENSIVE CARE UNIT	1,318	126,343	31.00
41.00	SUBPROVIDER - IRF	2,475	163,672	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	9,374	614,550	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,012,550	85,536,282	0.011838	14,009,280	165,842	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	183,937	13,471,098	0.013654	55,359	756	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	752,659	24,490,166	0.030733	1,575,331	48,415	54.00
54.01	03630	ULTRA SOUND	23,909	8,204,204	0.002914	455,878	1,328	54.01
56.00	05600	RADIOISOTOPE	90,278	19,302,004	0.004677	123,859	579	56.00
57.00	05700	CT SCAN	20,039	10,685,097	0.001875	1,111,992	2,085	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,383	2,930,175	0.004567	278,350	1,271	58.00
59.00	05900	CARDIAC CATHETERIZATION	27,768	1,787,397	0.015535	214,803	3,337	59.00
60.00	06000	LABORATORY	252,098	68,490,956	0.003681	11,095,956	40,844	60.00
65.00	06500	RESPIRATORY THERAPY	124,768	12,130,031	0.010286	3,751,411	38,587	65.00
66.00	06600	PHYSICAL THERAPY	219,795	13,904,695	0.015807	1,144,279	18,088	66.00
67.00	06700	OCCUPATIONAL THERAPY	84,900	4,589,508	0.018499	829,145	15,338	67.00
68.00	06800	SPEECH PATHOLOGY	24,370	1,014,272	0.024027	228,928	5,500	68.00
69.00	06900	ELECTROCARDIOLOGY	229,018	14,616,280	0.015669	1,809,176	28,348	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	79,285	6,744,909	0.011755	154,986	1,822	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	180,118	14,842,764	0.012135	3,587,463	43,534	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	81,156	12,974,948	0.006255	5,417,752	33,888	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	553,577	57,308,686	0.009660	4,936,898	47,690	73.00
74.00	07400	RENAL DIALYSIS	7,999	252,117	0.031727	146,665	4,653	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	104,020	5,364,054	0.019392	0	0	76.00
76.01	03190	CHEMOTHERAPY	153,606	5,021,049	0.030592	7,558	231	76.01
76.02	03330	ENDOSCOPY	89,829	3,026,209	0.029684	128,378	3,811	76.02
76.03	03950	WOUND CARE CENTER	73,599	14,279,671	0.005154	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	421,178	62,871,417	0.006699	5,737,571	38,436	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	59,952	2,308,574	0.025969	269,212	6,991	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	4,863,791	466,146,563		57,070,230	551,374	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	15,779	0.00	5,581	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,812	0.00	1,318	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	3,547	0.00	2,475	41.00
43.00	04300	NURSERY		0	2,162	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	23,300		9,374	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/26/2018 12:03 pm

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	218,444	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	73,190	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	172,193	56.00
57.00	05700	CT SCAN	0	0	0	0	95,322	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	26,140	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	585,289	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	85,536,282	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	13,471,098	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	218,444	218,444	24,490,166	0.008920	54.00
54.01	03630	ULTRA SOUND	0	73,190	73,190	8,204,204	0.008921	54.01
56.00	05600	RADIOISOTOPE	0	172,193	172,193	19,302,004	0.008921	56.00
57.00	05700	CT SCAN	0	95,322	95,322	10,685,097	0.008921	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	26,140	26,140	2,930,175	0.008921	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,787,397	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	68,490,956	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,130,031	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,904,695	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,589,508	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,014,272	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,616,280	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,744,909	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14,842,764	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,974,948	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	57,308,686	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	252,117	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	5,364,054	0.000000	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	5,021,049	0.000000	76.01
76.02	03330	ENDOSCOPY	0	0	0	3,026,209	0.000000	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	14,279,671	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	62,871,417	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,308,574	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	585,289	585,289	466,146,563		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	14,009,280	0	18,764,076	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	55,359	0	4,290	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.008920	1,575,331	14,052	6,573,131	58,632	54.00
54.01	03630	ULTRA SOUND	0.008921	455,878	4,067	2,213,831	19,750	54.01
56.00	05600	RADIOISOTOPE	0.008921	123,859	1,105	9,162,598	81,740	56.00
57.00	05700	CT SCAN	0.008921	1,111,992	9,920	3,082,996	27,503	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.008921	278,350	2,483	790,984	7,056	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	214,803	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	11,095,956	0	7,551,148	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,751,411	0	1,249,081	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,144,279	0	77,866	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	829,145	0	41,467	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	228,928	0	17,402	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,809,176	0	6,161,196	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	154,986	0	1,967,353	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	3,587,463	0	2,470,000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,417,752	0	1,623,209	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,936,898	0	18,335,618	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	146,665	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.000000	7,558	0	1,127,110	0	76.01
76.02	03330	ENDOSCOPY	0.000000	128,378	0	719,810	0	76.02
76.03	03950	WOUND CARE CENTER	0.000000	0	0	7,783,726	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	5,737,571	0	14,328,185	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	269,212	0	437,671	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		57,070,230	31,627	104,482,748	194,681	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.145457	18,764,076	0	0	2,729,366	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.248956	4,290	0	0	1,068	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223063	6,573,131	0	0	1,466,222	54.00
54.01	03630	ULTRA SOUND	0.090323	2,213,831	0	0	199,960	54.01
56.00	05600	RADIOISOTOPE	0.106369	9,162,598	0	0	974,616	56.00
57.00	05700	CT SCAN	0.079194	3,082,996	0	0	244,155	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.201076	790,984	0	0	159,048	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.163360	0	0	0	0	59.00
60.00	06000	LABORATORY	0.116029	7,551,148	0	0	876,152	60.00
65.00	06500	RESPIRATORY THERAPY	0.204461	1,249,081	0	0	255,388	65.00
66.00	06600	PHYSICAL THERAPY	0.334459	77,866	0	0	26,043	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373557	41,467	0	0	15,490	67.00
68.00	06800	SPEECH PATHOLOGY	0.439925	17,402	0	0	7,656	68.00
69.00	06900	ELECTROCARDIOLOGY	0.112278	6,161,196	0	0	691,767	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.167778	1,967,353	0	0	330,079	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.171343	2,470,000	0	0	423,217	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.301548	1,623,209	0	0	489,475	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.432219	18,335,618	0	6,383	7,925,002	73.00
74.00	07400	RENAL DIALYSIS	1.514658	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.444811	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	1.382876	1,127,110	0	0	1,558,653	76.01
76.02	03330	ENDOSCOPY	0.145136	719,810	0	0	104,470	76.02
76.03	03950	WOUND CARE CENTER	0.097611	7,783,726	0	0	759,777	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.083279	14,328,185	0	0	1,193,237	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.418340	437,671	0	91	183,095	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.228046		0			95.00
200.00		Subtotal (see instructions)		104,482,748	0	6,474	20,613,936	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		104,482,748	0	6,474	20,613,936	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,759		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
76.01	03190	CHEMOTHERAPY	0	0		76.01
76.02	03330	ENDOSCOPY	0	0		76.02
76.03	03950	WOUND CARE CENTER	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	38		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	2,797		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	2,797		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,012,550	85,536,282	0.011838	56,155	665	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	183,937	13,471,098	0.013654	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	752,659	24,490,166	0.030733	75,827	2,330	54.00
54.01	03630	ULTRA SOUND	23,909	8,204,204	0.002914	5,728	17	54.01
56.00	05600	RADIOISOTOPE	90,278	19,302,004	0.004677	0	0	56.00
57.00	05700	CT SCAN	20,039	10,685,097	0.001875	27,200	51	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,383	2,930,175	0.004567	6,650	30	58.00
59.00	05900	CARDIAC CATHETERIZATION	27,768	1,787,397	0.015535	0	0	59.00
60.00	06000	LABORATORY	252,098	68,490,956	0.003681	1,143,957	4,211	60.00
65.00	06500	RESPIRATORY THERAPY	124,768	12,130,031	0.010286	399,648	4,111	65.00
66.00	06600	PHYSICAL THERAPY	219,795	13,904,695	0.015807	1,206,028	19,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	84,900	4,589,508	0.018499	1,035,283	19,152	67.00
68.00	06800	SPEECH PATHOLOGY	24,370	1,014,272	0.024027	163,235	3,922	68.00
69.00	06900	ELECTROCARDIOLOGY	229,018	14,616,280	0.015669	16,652	261	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	79,285	6,744,909	0.011755	3,348	39	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	180,118	14,842,764	0.012135	246,699	2,994	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	81,156	12,974,948	0.006255	13,920	87	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	553,577	57,308,686	0.009660	510,377	4,930	73.00
74.00	07400	RENAL DIALYSIS	7,999	252,117	0.031727	19,684	625	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	104,020	5,364,054	0.019392	0	0	76.00
76.01	03190	CHEMOTHERAPY	153,606	5,021,049	0.030592	0	0	76.01
76.02	03330	ENDOSCOPY	89,829	3,026,209	0.029684	0	0	76.02
76.03	03950	WOUND CARE CENTER	73,599	14,279,671	0.005154	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	421,178	62,871,417	0.006699	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,308,574	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	4,803,839	466,146,563		4,930,391	62,489	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	218,444	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	73,190	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	172,193	56.00
57.00	05700	CT SCAN	0	0	0	0	95,322	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	26,140	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	585,289	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	85,536,282	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	13,471,098	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	218,444	218,444	24,490,166	0.008920	54.00
54.01	03630	ULTRA SOUND	0	73,190	73,190	8,204,204	0.008921	54.01
56.00	05600	RADIOISOTOPE	0	172,193	172,193	19,302,004	0.008921	56.00
57.00	05700	CT SCAN	0	95,322	95,322	10,685,097	0.008921	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	26,140	26,140	2,930,175	0.008921	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,787,397	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	68,490,956	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,130,031	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,904,695	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,589,508	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,014,272	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,616,280	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,744,909	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14,842,764	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,974,948	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	57,308,686	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	252,117	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	5,364,054	0.000000	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	5,021,049	0.000000	76.01
76.02	03330	ENDOSCOPY	0	0	0	3,026,209	0.000000	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	14,279,671	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	62,871,417	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,308,574	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	585,289	585,289	466,146,563		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	56,155	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.008920	75,827	676	0	0	54.00
54.01	03630	ULTRA SOUND	0.008921	5,728	51	0	0	54.01
56.00	05600	RADIOISOTOPE	0.008921	0	0	0	0	56.00
57.00	05700	CT SCAN	0.008921	27,200	243	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.008921	6,650	59	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,143,957	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	399,648	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,206,028	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,035,283	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	163,235	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	16,652	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	3,348	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	246,699	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	13,920	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	510,377	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	19,684	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.000000	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0.000000	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		4,930,391	1,029	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 11/26/2018 12:03 pm

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	15,779	0.00	190	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,812	0.00	257	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	3,547	0.00	15	41.00
43.00	04300	NURSERY		0	2,162	0.00	51	43.00
200.00		Total (lines 30 through 199)		0	23,300		513	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/26/2018 12:03 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	218,444	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	73,190	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	172,193	56.00
57.00	05700	CT SCAN	0	0	0	0	95,322	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	26,140	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	585,289	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/26/2018 12:03 pm

Title XIX | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	85,536,282	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	13,471,098	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	218,444	218,444	24,490,166	0.008920	54.00
54.01	03630	ULTRA SOUND	0	73,190	73,190	8,204,204	0.008921	54.01
56.00	05600	RADIOISOTOPE	0	172,193	172,193	19,302,004	0.008921	56.00
57.00	05700	CT SCAN	0	95,322	95,322	10,685,097	0.008921	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	26,140	26,140	2,930,175	0.008921	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,787,397	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	68,490,956	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,130,031	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,904,695	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,589,508	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,014,272	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,616,280	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,744,909	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14,842,764	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,974,948	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	57,308,686	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	252,117	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	5,364,054	0.000000	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	5,021,049	0.000000	76.01
76.02	03330	ENDOSCOPY	0	0	0	3,026,209	0.000000	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	14,279,671	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	62,871,417	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,308,574	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	585,289	585,289	466,146,563		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/26/2018 12:03 pm

Title XIX | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	2,889,395	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	4,924,588	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.008920	237,617	2,120	0	0	54.00
54.01	03630	ULTRA SOUND	0.008921	117,102	1,045	0	0	54.01
56.00	05600	RADIOISOTOPE	0.008921	73,480	656	0	0	56.00
57.00	05700	CT SCAN	0.008921	221,635	1,977	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.008921	51,203	457	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	78,421	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	3,794,777	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	849,750	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	203,037	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	72,574	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	18,092	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	183,634	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	16,947	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	547,518	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	694,583	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,702,515	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	15,548	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	3,111	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.000000	14,917	0	0	0	76.01
76.02	03330	ENDOSCOPY	0.000000	31,720	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.000000	60,002	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	1,231,478	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		18,033,644	6,255	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 12:03 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.145457	0	5,960,565	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.248956	0	639,526	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223063	0	2,627,839	0	0	54.00
54.01	03630	ULTRA SOUND	0.090323	0	775,128	0	0	54.01
56.00	05600	RADIOISOTOPE	0.106369	0	1,644,334	0	0	56.00
57.00	05700	CT SCAN	0.079194	0	1,276,938	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.201076	0	299,256	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.163360	0	114,710	0	0	59.00
60.00	06000	LABORATORY	0.116029	0	8,087,484	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.204461	0	542,374	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.334459	0	1,227,543	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373557	0	206,921	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.439925	0	54,256	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.112278	0	701,097	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.167778	0	931,600	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.171343	0	383,895	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.301548	0	487,010	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.432219	0	5,745,344	0	0	73.00
74.00	07400	RENAL DIALYSIS	1.514658	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.444811	0	1,654,832	0	0	76.00
76.01	03190	CHEMOTHERAPY	1.382876	0	548,819	0	0	76.01
76.02	03330	ENDOSCOPY	0.145136	0	258,767	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.097611	0	1,386,402	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.083279	0	14,886,731	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.418340	0	439,786	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.228046	0	1,796,950			95.00
200.00		Subtotal (see instructions)		0	52,678,107	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	52,678,107	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/26/2018 12:03 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	867,006	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	159,214	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	586,174	0	54.00
54.01	03630	ULTRA SOUND	70,012	0	54.01
56.00	05600	RADIOISOTOPE	174,906	0	56.00
57.00	05700	CT SCAN	101,126	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	60,173	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,739	0	59.00
60.00	06000	LABORATORY	938,383	0	60.00
65.00	06500	RESPIRATORY THERAPY	110,894	0	65.00
66.00	06600	PHYSICAL THERAPY	410,563	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	77,297	0	67.00
68.00	06800	SPEECH PATHOLOGY	23,869	0	68.00
69.00	06900	ELECTROCARDIOLOGY	78,718	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	156,302	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	65,778	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	146,857	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,483,247	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	736,087	0	76.00
76.01	03190	CHEMOTHERAPY	758,949	0	76.01
76.02	03330	ENDOSCOPY	37,556	0	76.02
76.03	03950	WOUND CARE CENTER	135,328	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	1,239,752	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	183,980	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	409,787		95.00
200.00		Subtotal (see instructions)	10,030,697	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	10,030,697	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,779	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,779	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	14,748	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,581	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	14,780,623	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	14,780,623	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	14,780,623	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	936.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,227,890	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	5,227,890	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,254,991	1,812	1,796.35	1,318	2,367,589	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	10,937,144	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	18,532,623	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	450,878	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	583,001	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,033,879	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	17,498,744	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,031	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	936.73	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	965,769	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	917,542	14,780,623	0.062077	965,769	59,952	90.00
91.00	Nursing School cost	0	14,780,623	0.000000	965,769	0	91.00
92.00	Allied health cost	0	14,780,623	0.000000	965,769	0	92.00
93.00	All other Medical Education	0	14,780,623	0.000000	965,769	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/26/2018 12:03 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,547	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,547	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,547	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,475	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,002,694	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,002,694	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,002,694	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	846.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,095,187	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,095,187	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,404,759	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,499,946	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	163,672	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	63,518	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	227,190	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,272,756	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1

Component CCN: 15-T010 | Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	234,554	3,002,694	0.078115	0	0	90.00
91.00	Nursing School cost	0	3,002,694	0.000000	0	0	91.00
92.00	Allied health cost	0	3,002,694	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,002,694	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 12:03 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,779	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,779	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	14,748	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	190	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	2,162	15.00
16.00	Nursery days (title V or XIX only)	51	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	14,780,623	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	14,780,623	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	14,780,623	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	936.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	177,979	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	177,979	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 12:03 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,227,483	2,162	567.75	51	28,955	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,254,991	1,812	1,796.35	257	461,662	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,696,530	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,365,126	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,031	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	936.73	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	965,769	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 12:03 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	917,542	14,780,623	0.062077	965,769	59,952	90.00
91.00	Nursing School cost	0	14,780,623	0.000000	965,769	0	91.00
92.00	Allied health cost	0	14,780,623	0.000000	965,769	0	92.00
93.00	All other Medical Education	0	14,780,623	0.000000	965,769	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/26/2018 12:03 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,547	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,547	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,547	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	15	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	2,162	15.00
16.00	Nursery days (title V or XIX only)	51	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,002,694	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,002,694	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,002,694	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	846.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	12,698	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	12,698	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/26/2018 12:03 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	19,522	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	32,220	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1

Component CCN: 15-T010 | Date/Time Prepared: 11/26/2018 12:03 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	234,554	3,002,694	0.078115	0	0	90.00
91.00	Nursing School cost	0	3,002,694	0.000000	0	0	91.00
92.00	Allied health cost	0	3,002,694	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,002,694	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,990,111		30.00
31.00	03100	INTENSIVE CARE UNIT		3,642,160		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.145457	14,009,280	2,037,748	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.248956	55,359	13,782	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223063	1,575,331	351,398	54.00
54.01	03630	ULTRA SOUND	0.090323	455,878	41,176	54.01
56.00	05600	RADIOISOTOPE	0.107082	123,859	13,263	56.00
57.00	05700	CT SCAN	0.079194	1,111,992	88,063	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.201076	278,350	55,970	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.163360	214,803	35,090	59.00
60.00	06000	LABORATORY	0.116029	11,095,956	1,287,453	60.00
65.00	06500	RESPIRATORY THERAPY	0.204461	3,751,411	767,017	65.00
66.00	06600	PHYSICAL THERAPY	0.334459	1,144,279	382,714	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373557	829,145	309,733	67.00
68.00	06800	SPEECH PATHOLOGY	0.439925	228,928	100,711	68.00
69.00	06900	ELECTROCARDIOLOGY	0.112278	1,809,176	203,131	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.167778	154,986	26,003	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.171343	3,587,463	614,687	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.301548	5,417,752	1,633,712	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.432219	4,936,898	2,133,821	73.00
74.00	07400	RENAL DIALYSIS	1.514658	146,665	222,147	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.444811	0	0	76.00
76.01	03190	CHEMOTHERAPY	1.382876	7,558	10,452	76.01
76.02	03330	ENDOSCOPY	0.145136	128,378	18,632	76.02
76.03	03950	WOUND CARE CENTER	0.097611	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.083279	5,737,571	477,819	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.418340	269,212	112,622	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		57,070,230	10,937,144	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		57,070,230		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		4,119,011		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.145457	56,155	8,168	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.248956	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223063	75,827	16,914	54.00
54.01	03630	ULTRA SOUND	0.090323	5,728	517	54.01
56.00	05600	RADIOISOTOPE	0.107082	0	0	56.00
57.00	05700	CT SCAN	0.079194	27,200	2,154	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.201076	6,650	1,337	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.163360	0	0	59.00
60.00	06000	LABORATORY	0.116029	1,143,957	132,732	60.00
65.00	06500	RESPIRATORY THERAPY	0.204461	399,648	81,712	65.00
66.00	06600	PHYSICAL THERAPY	0.334459	1,206,028	403,367	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373557	1,035,283	386,737	67.00
68.00	06800	SPEECH PATHOLOGY	0.439925	163,235	71,811	68.00
69.00	06900	ELECTROCARDIOLOGY	0.112278	16,652	1,870	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.167778	3,348	562	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.171343	246,699	42,270	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.301548	13,920	4,198	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.432219	510,377	220,595	73.00
74.00	07400	RENAL DIALYSIS	1.514658	19,684	29,815	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.444811	0	0	76.00
76.01	03190	CHEMOTHERAPY	1.382876	0	0	76.01
76.02	03330	ENDOSCOPY	0.145136	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.097611	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.083279	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.418340	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,930,391	1,404,759	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,930,391		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 12:03 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		5,572,345		30.00
31.00	03100	INTENSIVE CARE UNIT		31,707		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		2,027,718		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.145457	2,889,395	420,283	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.248956	4,924,588	1,226,006	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223063	237,617	53,004	54.00
54.01	03630	ULTRA SOUND	0.090323	117,102	10,577	54.01
56.00	05600	RADIOISOTOPE	0.106369	73,480	7,816	56.00
57.00	05700	CT SCAN	0.079194	221,635	17,552	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.201076	51,203	10,296	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.163360	78,421	12,811	59.00
60.00	06000	LABORATORY	0.116029	3,794,777	440,304	60.00
65.00	06500	RESPIRATORY THERAPY	0.204461	849,750	173,741	65.00
66.00	06600	PHYSICAL THERAPY	0.334459	203,037	67,908	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373557	72,574	27,111	67.00
68.00	06800	SPEECH PATHOLOGY	0.439925	18,092	7,959	68.00
69.00	06900	ELECTROCARDIOLOGY	0.112278	183,634	20,618	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.167778	16,947	2,843	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.171343	547,518	93,813	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.301548	694,583	209,450	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.432219	1,702,515	735,859	73.00
74.00	07400	RENAL DIALYSIS	1.514658	15,548	23,550	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.444811	3,111	1,384	76.00
76.01	03190	CHEMOTHERAPY	1.382876	14,917	20,628	76.01
76.02	03330	ENDOSCOPY	0.145136	31,720	4,604	76.02
76.03	03950	WOUND CARE CENTER	0.097611	60,002	5,857	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.083279	1,231,478	102,556	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.418340	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		18,033,644	3,696,530	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		18,033,644		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/26/2018 12:03 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		133,671		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.145457	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.248956	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223063	594	132	54.00
54.01	03630	ULTRA SOUND	0.090323	0	0	54.01
56.00	05600	RADIOISOTOPE	0.106369	0	0	56.00
57.00	05700	CT SCAN	0.079194	1,154	91	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.201076	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.163360	0	0	59.00
60.00	06000	LABORATORY	0.116029	14,109	1,637	60.00
65.00	06500	RESPIRATORY THERAPY	0.204461	8,525	1,743	65.00
66.00	06600	PHYSICAL THERAPY	0.334459	29,439	9,846	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373557	6,952	2,597	67.00
68.00	06800	SPEECH PATHOLOGY	0.439925	1,733	762	68.00
69.00	06900	ELECTROCARDIOLOGY	0.112278	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.167778	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.171343	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.301548	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.432219	6,279	2,714	73.00
74.00	07400	RENAL DIALYSIS	1.514658	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.444811	0	0	76.00
76.01	03190	CHEMOTHERAPY	1.382876	0	0	76.01
76.02	03330	ENDOSCOPY	0.145136	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.097611	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.083279	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.418340	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		68,785	19,522	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		68,785		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/26/2018 12:03 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	3,640,398	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	11,148,767	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	230,116	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	104.18	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.33	30.00
31.00	Percentage of Medicaid patient days (see instructions)	26.24	31.00
32.00	Sum of lines 30 and 31	29.57	32.00
33.00	Allowable disproportionate share percentage (see instructions)	13.61	33.00
34.00	Disproportionate share adjustment (see instructions)	503,202	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000142294	0.000136154	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	850,562	921,313	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	214,388	689,091	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	903,479		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	2,208		40.00

		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	16,425,962		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	16,425,962	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,284,076	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	31,194	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	31,627	58.00
59.00	Total (sum of amounts on lines 49 through 58)	17,772,859	59.00
60.00	Primary payer payments	5,000	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	17,767,859	61.00
62.00	Deductibles billed to program beneficiaries	1,730,176	62.00
63.00	Coinsurance billed to program beneficiaries	20,536	63.00
64.00	Allowable bad debts (see instructions)	126,833	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	82,441	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	29,951	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	16,099,588	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-981	70.93
70.94	HRR adjustment amount (see instructions)	-4,459	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/26/2018 12:03 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		16,094,148	71.00
71.01	Sequestration adjustment (see instructions)		321,883	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		15,606,153	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		166,112	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		407,849	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,640,398	0	3,640,398		3,640,398	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,148,767	0		11,148,767	11,148,767	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	230,116	0	88,133	141,982	230,115	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1361	0.1361	0.1361	0.1361		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	503,202	0	123,865	379,337	503,202	11.00
11.01	Uncompensated care payments	36.00	903,479	0	214,388	689,091	903,479	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	16,425,962	0	4,066,784	12,359,178	16,425,962	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	16,425,962	0	4,066,784	12,359,178	16,425,962	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,284,076	0	315,572	968,504	1,284,076	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	4,382,356	13,327,682	17,710,038	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,197,217	0	292,731	904,486	1,197,217	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	12,991	0	4,779	8,212	12,991	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0617	0.0617	0.0617	0.0617		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	73,868	0	18,062	55,806	73,868	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,284,076	0	315,572	968,504	1,284,076	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,640,398	3,640,398		3,640,398	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,148,767		11,148,767	11,148,767	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	230,116	88,133	141,982	230,115	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1361	0.1361	0.1361		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	503,202	123,865	379,337	503,202	11.00
11.01	Uncompensated care payments	36.00	903,479	214,388	689,091	903,479	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	16,425,962	4,066,784	12,359,178	16,425,962	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	16,425,962	4,066,784	12,359,178	16,425,962	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,284,076	315,572	968,504	1,284,076	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			4,382,356	13,327,682	17,710,038	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,197,217	292,731	904,486	1,197,217	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	12,991	4,779	8,212	12,991	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0617	0.0617	0.0617		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	73,868	18,062	55,806	73,868	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,284,076	315,572	968,504	1,284,076	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-981	-12,055	11,074	-981	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-4,459	0	-4,459	-4,459	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/26/2018 12:03 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,797	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	20,419,255	2.00
3.00	OPPS payments	18,650,216	3.00
4.00	Outlier payment (see instructions)	155,552	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	194,681	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,797	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	6,474	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	6,474	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	6,474	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,677	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	2,797	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	19,000,449	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,547,280	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	15,455,966	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	15,455,966	30.00
31.00	Primary payer payments	1,588	31.00
32.00	Subtotal (line 30 minus line 31)	15,454,378	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	369,595	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	240,237	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	161,335	36.00
37.00	Subtotal (see instructions)	15,694,615	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	15,694,615	40.00
40.01	Sequestration adjustment (see instructions)	313,892	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	15,363,576	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	17,147	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		15,606,153		15,363,576	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		15,606,153		15,363,576	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		166,112		17,147	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		15,772,265		15,380,723	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/26/2018 12:03 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,980,807		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,980,807		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		2,196		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,983,003		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0010	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/26/2018 12:03 pm
	Title XVIII	Hospital	PPS

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part III Date/Time Prepared: 11/26/2018 12:03 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	3,963,754	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0382	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	88,788	3.00
4.00	Outlier Payments	53,919	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	9.717808	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	4,106,461	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	4,106,461	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	4,106,461	19.00
20.00	Deductibles	45,104	20.00
21.00	Subtotal (line 19 minus line 20)	4,061,357	21.00
22.00	Coinsurance	0	22.00
23.00	Subtotal (line 21 minus line 22)	4,061,357	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	2,928	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	1,903	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,667	26.00
27.00	Subtotal (sum of lines 23 and 25)	4,063,260	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	1,029	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	4,064,289	32.00
32.01	Sequestration adjustment (see instructions)	81,286	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	3,980,807	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	2,196	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	49,942	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	53,919	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 11/26/2018 12:03 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	4,365,126		1.00
2.00	Medical and other services		10,030,697	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	4,365,126	10,030,697	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	4,365,126	10,030,697	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	7,631,770		8.00
9.00	Ancillary service charges	18,033,644	52,678,107	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	25,665,414	52,678,107	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	25,665,414	52,678,107	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	21,300,288	42,647,410	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	4,365,126	10,030,697	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	4,365,126	10,030,697	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	4,365,126	10,030,697	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	4,365,126	10,030,697	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	4,365,126	10,030,697	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	4,365,126	10,030,697	40.00
41.00	Interim payments	4,365,126	10,030,697	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 11/26/2018 12:03 pm
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	32,220		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	32,220	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	32,220	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	133,671		8.00
9.00	Ancillary service charges	68,785	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	202,456	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	202,456	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	170,236	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	32,220	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	32,220	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	32,220	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	32,220	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	32,220	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	32,220	0	40.00
41.00	Interim payments	32,220	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/26/2018 12:03 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,275	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	46,012,159	0	0	0	4.00
5.00	Other receivable	1,017,471	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-25,499,214	0	0	0	6.00
7.00	Inventory	1,949,709	0	0	0	7.00
8.00	Prepaid expenses	118,643	0	0	0	8.00
9.00	Other current assets	3,210,264	0	0	0	9.00
10.00	Due from other funds	722,779	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	27,533,086	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,764,978	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-1,466,917	0	0	0	14.00
15.00	Buildings	63,507,337	0	0	0	15.00
16.00	Accumulated depreciation	-53,597,860	0	0	0	16.00
17.00	Leasehold improvements	528,071	0	0	0	17.00
18.00	Accumulated depreciation	-528,071	0	0	0	18.00
19.00	Fixed equipment	24,373,785	0	0	0	19.00
20.00	Accumulated depreciation	-20,658,048	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	40,646,037	0	0	0	23.00
24.00	Accumulated depreciation	-34,603,969	0	0	0	24.00
25.00	Minor equipment depreciable	603,752	0	0	0	25.00
26.00	Accumulated depreciation	-522,480	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	9,757	0	0	0	28.00
29.00	Minor equipment-nondepreciable	4,584,090	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	24,640,462	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	107,769	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	107,769	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	52,281,317	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	7,617,362	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,115,471	0	0	0	38.00
39.00	Payroll taxes payable	2,269,274	0	0	0	39.00
40.00	Notes and loans payable (short term)	220,652	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	12,299,855	0	0	0	43.00
44.00	Other current liabilities	1,913,584	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	25,436,198	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	15,482,494	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,937,907	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	17,420,401	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	42,856,599	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	9,424,718				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	9,424,718	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	52,281,317	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/26/2018 12:03 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		5,273,081		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		19,357,596				2.00
3.00	Total (sum of line 1 and line 2)		24,630,677		0		3.00
4.00	RESTRICTED ACTIVITY	175,068		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		175,068		0		10.00
11.00	Subtotal (line 3 plus line 10)		24,805,745		0		11.00
12.00	TRANSFER TO/FROM AFFILIATES	15,381,027		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		15,381,027		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,424,718		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	RESTRICTED ACTIVITY		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	TRANSFER TO/FROM AFFILIATES		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/26/2018 12:03 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	32,315,308		32,315,308	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	5,988,750		5,988,750	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	38,304,058		38,304,058	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	7,358,631		7,358,631	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	7,358,631		7,358,631	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	45,662,689		45,662,689	17.00
18.00	Ancillary services	128,934,169	0	128,934,169	18.00
19.00	Outpatient services	0	344,275,993	344,275,993	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	94,333	94,333	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	174,596,858	344,370,326	518,967,184	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		133,489,959		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		133,489,959		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-3 | Date/Time Prepared: 11/26/2018 12:03 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	518,967,184	1.00
2.00	Less contractual allowances and discounts on patients' accounts	365,268,888	2.00
3.00	Net patient revenues (line 1 minus line 2)	153,698,296	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	133,489,959	4.00
5.00	Net income from service to patients (line 3 minus line 4)	20,208,337	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	14,000	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	483,923	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	11,219	17.00
18.00	Revenue from sale of medical records and abstracts	484	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	26,083	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	23,325	23.00
24.00	OTHER MISCELLANEOUS INCOME	461,055	24.00
24.01	INVESTMENT INCOME	4,975	24.01
25.00	Total other income (sum of lines 6-24)	1,025,064	25.00
26.00	Total (line 5 plus line 25)	21,233,401	26.00
27.00	IMPAIRMENT, RESTRUCTURING, NONRECURR	1,192,884	27.00
27.01	BAD DEBT EXPENSE	682,921	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	1,875,805	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	19,357,596	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0010	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/26/2018 12:03 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,197,217	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	12,991	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	47.13	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	3.33	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	26.24	8.00
9.00	Sum of lines 7 and 8	29.57	9.00
10.00	Allowable disproportionate share percentage (see instructions)	6.17	10.00
11.00	Disproportionate share adjustment (see instructions)	73,868	11.00
12.00	Total prospective capital payments (see instructions)	1,284,076	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00